BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of ARM 37.86.2803, 37.86.2904, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.3007, 37.86.3020, and 37.86.3105 pertaining to Medicaid reimbursement for inpatient and outpatient hospital services	)	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On September 13, 2006, at 3:00 p.m., a public hearing will be held in Room 207 of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice or provide reasonable accommodations at the public hearing site. If you need to request an accommodation, contact the department no later than 5:00 p.m. on September 5, 2006, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970; e-mail dphhslegal@mt.gov.

2. The rules as proposed to be amended provide as follows. Matter to be added is underlined. Matter to be deleted is interlined.

37.86.2803 ALL HOSPITAL REIMBURSEMENT, COST REPORTING

(1) Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, CMS Publication 15 last updated ~~April 2005~~ February 2006 (Pub. 15), subject to the exceptions and limitations provided in the department's administrative rules. The department adopts and incorporates by reference Pub. 15, which is a manual published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), which provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of Pub. 15 may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(a) remains the same.

(b) For cost report periods ending on or after July 1, 2003, for each hospital which is not a sole community hospital, critical access hospital, or exempt hospital as defined in ARM 37.86.2901, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined in accordance with (1)~~, less 5.8% of such costs~~.

(c) through (4) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-149, MCA

37.86.2904 INPATIENT HOSPITAL SERVICES, BILLING REQUIREMENTS

(1) through (5) remain the same.

(6) The Medicaid statewide average cost to charge ratio excluding capital expenses is ~~56%~~ 50%.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2907 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, DRG PAYMENT RATE DETERMINATION (1) The department's DRG prospective payment rate for inpatient hospital services is based on the classification of inpatient hospital discharges to DRGs. The procedure for determining the DRG prospective payment rate is as follows:

(a) and (b) remain the same.

(c) The department computes a Montana average base price per case. This average base price per case is $1980 excluding capital expenses, medical education, and disproportionate share hospital payments effective for services provided from August 1, 2003 through December 31, 2005. For services provided January 1, 2006 through June 30, 2006, the average base price per case is $2037 excluding capital expenses, medical education, and disproportionate share hospital payments. For services provided between July 1, 2006 and September 30, 2006, the average base price is $2118 excluding capital expenses, medical education, and disproportionate share hospital payments. For services provided on or after ~~July 1, 2006~~ October 1, 2006, the average base price is ~~$2118~~ $2025 excluding capital expenses, medical education, and disproportionate share hospital payments.

(d) remains the same.

(2) For those Montana hospitals designated by the department after July 15, 2005 as having met the requirements for a specialty (level II) and subspecialty (level III) neonatal intensive care facility as provided in the Guidelines for Perinatal Care, Fifth Edition (2002), published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, reimbursement for neonatal DRGs 385 through 389 will be actual allowable cost determined on a retrospective basis, with allowable costs determined according to ARM 37.86.2803. The guidelines are adopted and incorporated by reference and are available through the Department of Public Health and Human Services, Health Resources Division, 1400

Broadway, P.O. Box 202951, Helena, MT 59620-2951. In addition, such facilities:

(a) and (b) remain the same.

(c) will not receive any cost outlier payment ~~or other add-on payment~~ with respect to such discharges or services.

(3) The Montana Medicaid DRG relative weight values, average length of stay (ALOS), and outlier thresholds are contained in the DRG Table of Weights and Thresholds (effective ~~July 1, 2006~~ October 1, 2006) published by the department. The department adopts and incorporates by reference the DRG Table of Weights and Thresholds (effective ~~July 1, 2006~~ October 1, 2006). Copies may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2912 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, CAPITAL-RELATED COSTS (1) The department will reimburse inpatient hospital service providers located in the state of Montana for capital-related costs that are allowable under Medicare cost reimbursement principles as set forth at 42 CFR 412.113(a), as amended through ~~October 1, 2004~~ October 1, 2005. The department adopts and incorporates by reference 42 CFR 412.113(a) and (b), as amended through ~~October 1, 2004~~ October 1, 2005, which set forth Medicare cost reimbursement principles. Copies of the cited regulation may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) remains the same.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2914 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, MEDICAL EDUCATION COSTS (1) The department shall reimburse inpatient hospital service providers for medical education related costs that are allowable under Medicare cost reimbursement principles as set forth at 42 CFR 412.113(b), as amended through October 1, ~~1992~~ 2005.

(2) remains the same.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2916 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, COST OUTLIERS (1) In addition to the DRG payment, providers reimbursed under the DRG prospective payment system may receive payment as provided in this rule for cost outliers for DRGs ~~other than neonatal DRGs 385 through 389 provided by neonatal intensive care units described in ARM 37.86.2907~~.

(2) and (3) remain the same.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2918 INPATIENT HOSPITAL, READMISSIONS, AND TRANSFERS

(1) and (2) remain the same.

(3) A transfer, for the purpose of this rule, is limited to those instances in which a patient is transferred for continuation of medical treatment between two hospitals, one of which is paid under the Montana Medicaid prospective payment system.

(a) A transferring hospital reimbursed under the DRG prospective payment system is paid for the services and items provided to the transferred recipient, the lesser of:

(i) a per diem rate of two times the average per diem amount for the first inpatient day plus one per diem payment for each subsequent day of inpatient care determined by dividing the sum of the DRG payment for the case as computed in ARM 37.86.2907 and the appropriate outlier, capital, medical education, and DSH add-ons as computed in ARM 37.86.2912, 37.86.2914, 37.86.2916, and 37.86.2925, if any, by the statewide average length of stay for the DRG; or

(ii) the sum of the DRG payment for the case as computed in ARM 37.86.2907 and the appropriate outlier, capital, medical education, and DSH add-ons as computed in ARM 37.86.2912, 37.86.2914, 37.86.2916, and 37.86.2925, if any.

(b) A discharging hospital (i.e., the hospital to which the recipient is transferred) reimbursed under ARM 37.86.2907 is paid the full DRG payment plus any appropriate outliers, capital, medical education, and DSH add-ons, if any.

(4) and (5) remain the same.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3007 OUTPATIENT HOSPITAL SERVICES, PROSPECTIVE PAYMENT METHODOLOGY, CLINICAL DIAGNOSTIC LABORATORY SERVICES

(1) Clinical diagnostic laboratory services, including automated multichannel test panels (commonly referred to as "ATPs") and lab panels, will be reimbursed on a fee basis as follows with the exception of hospitals reimbursed under ARM 37.86.3005 and specific lab codes which are paid under ARM 37.86.3020:

(a) and (b) remain the same.

(c) For purposes of this rule, clinical diagnostic laboratory services include the laboratory tests listed in codes defined in the HCPCS and listed in the Clinical Diagnostic Fee Schedule (CLAB) published December 14, 2005. ~~Certain tests are exempt from the fee schedule. These tests are listed in the CMS Publication 45 (Pub. 45) last modified August 28, 2002, State Medicaid Manual, Payment For Services, Section 6300. These exempt clinical diagnostic laboratory services will be reimbursed under the retrospective payment methodology specified in ARM 37.86.3005(2).~~

(d) remains the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3020 OUTPATIENT HOSPITAL SERVICES, OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) METHODOLOGY, AMBULATORY PAYMENT CLASSIFICATION (1) Outpatient hospital services that are not provided by exempt hospitals or critical access hospitals as defined in ARM 37.86.2901(4) and (8) will be reimbursed on a rate-per-service basis using the Outpatient Prospective Payment System (OPPS) schedules. Under this system, Medicaid payment for hospital outpatient services included in the OPPS is made at a predetermined, specific rate. These outpatient services are classified according to a list of APCs published annually in the Code of Federal Regulations (CFR). The rates for OPPS are determined as follows:

(a) The department uses a conversion factor for each APC group ~~based on Montana's highest Medicare urban rate, as published annually in the CFR~~ as defined at ARM 37.86.3001(2). The APC based fee equals the Medicare specific relative weight for the APC times the conversion factor that is the same for all APCs with the exceptions of services in ARM 37.86.3025. APCs are based on classification assignment of HCPCS codes.

(b) through (h) remain the same.

(2) The department adopts and incorporates by reference the OPPS Schedules published by the Centers for Medicare and Medicaid Services (CMS) in ~~69~~ 70 Federal Register ~~211~~ 217, November ~~2, 2004~~ 10, 2005, effective January 1, ~~2005~~ 2006. A copy may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3105 OUTPATIENT HOSPITAL SERVICES, PULMONARY REHABILITATION SERVICES (1) and (2) remain the same.

~~(3) The patient must have a referral to individual case management (ICM) before receiving pulmonary rehabilitation services.~~

(4) remains the same but is renumbered (3).

AUTH: 53-2-201, 53-6-111, MCA
IMP: 53-2-201, 53-6-101, MCA

3. The Department of Public Health and Human Services (the department) is proposing the amendment of ARM 37.86.2803, 37.86.2904, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.3007, 37.86.3020, and 37.86.3105 pertaining to Medicaid reimbursement for inpatient hospital services. The purpose of the proposed rule amendments is to adjust the cost to charge ratio for inpatient hospital services paid under the Prospective Payment System (PPS), to expand and restructure certain DRG rules to make them more comprehensive and easier to understand, to update obsolete references to federal publications and regulations, to

correct errors, and to remove obsolete and redundant rule provisions.

ARM 37.86.2803

The department proposes an update of this rule pertaining to cost reporting. United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) issued a revised Publication 15, the Medicare Provider Reimbursement Manual dated February 2006. If this reference was not updated, providers of Medicaid hospital services that also provide Medicare hospital services would be required to use the April 2005 version of Publication 15 for Medicaid cost reporting and the February 2006 version for Medicare cost reporting. The department's proposed amendment would simplify cost reporting duties for those providers. The department does not intend the proposed amendment to have any effect on rates.

The department is taking this opportunity to delete an obsolete provision in ARM 37.86.2803(1)(b). In July 2003, when the department amended its rules to eliminate a 5.8% reduction to cost reports, this rule subsection was overlooked. The proposed amendment would correct the oversight and delete the obsolete provision. If the proposed amendment was not adopted, there would be confusion about the applicability of the former cost reporting methodology.

ARM 37.86.2904

The department is proposing to amend the statewide cost to charge ratio to 50% to match a trend reflected in hospital cost reports from 1999 through 2004. The current statewide cost to charge ratio was established at 56%, using 1999 cost reports, and has not been amended since that time.

The actual statewide cost to charge ratios for hospitals reimbursed under PPS were:

1999	55.2%
2000	53.9%
2001	52.6%
2002	51.7%
2003	50.7%
2004	49.4%

The proposed statewide cost to charge ratio includes only hospitals reimbursed under PPS and would no longer include Critical Access Hospitals. Critical Access Hospitals are reimbursed 101% of costs and their cost to charge ratios are typically 20% higher than PPS hospitals. In 1999, there were only 12 Critical Access Hospitals with total charges of $820,313.00. In 2004, those numbers jumped to 42 Critical Access Hospitals with total charges of $7,825,589. The department finds that including the Critical Access Hospitals in the cost to charge ratio for PPS hospitals would significantly taint the calculations. While the proposed method of computing cost to charge ratios will more accurately reflect costs, the change would

reduce the overall payment of outliers and exempt DRGs to PPS hospitals.

ARM 37.86.2907

Montana's method of payment for inpatient hospital services is prospective payment using the Diagnosis Related Groups (DRG). On June 12, 2006, the department adopted a payment method in which the payment for a Medicaid inpatient hospital service equals the relative weight of the DRG for that service times the base price plus all applicable add-ons, such as medical education, capital and disproportionate share hospital payments. The payment method is also designed to give hospitals an added measure of financial support to help cover the costs of exceptionally expensive cases by also paying an "outlier" amount. The charges for medically necessary services are multiplied by the cost to charge ratio and then compared to the cost outlier threshold for the appropriate DRG. Costs exceeding the threshold are multiplied by a marginal cost ratio (60%) to determine the outlier reimbursement amount.

Montana Medicaid has chosen to develop its own set of relative weights because Montana's population differs significantly from Medicare's population. Also, because of Montana's sparse population, it is awkward to adopt relative weights that reflect much more urban styles of practice. The relative weights are based on data from inpatient stays in Montana hospitals in SFY 2002 to 2005 paid utilizing the DRG system. As of the date of this notice, SFY 2005 claims are still incomplete. The data set includes claims as of June 30, 2005. The geometric mean (geomean) of the charge amounts for each individual DRG was calculated. These calculated charge amounts were used as the measure to calculate the relative weights. The new relative weights were set so they average to 1.0 for the claims that would be paid on a DRG basis. For example, if a given DRG had geomean charges of $6,000, and the geomean charge for all DRGs was $3,000, then that DRG would be assigned a relative weight of 2.0000. Some DRGs had very low volumes. If there were fewer than five cases within the time frame for a particular DRG, then that DRG was made exempt from prospective payment. These DRGs are paid on a cost-to-charge ratio because they are so rare that stable weights cannot be calculated with confidence. A total of 530 valid DRGs were evaluated because 22 DRGs are no longer valid. Of these, 121 DRGs have a “0” relative weight because there were fewer than five cases per DRG.

When claims paid on a DRG basis are unusually expensive, they may become eligible for cost outlier payments. Cost outlier thresholds are set separately for each DRG so that outlier payments will not exceed an average of 10% of the payments for that DRG. The Medicare program aims for a range between 5% and 8%. The cost outlier thresholds are multiples of the DRG rate. The Montana Medicaid program has used this approach since at least 1993. The Medicare program uses a different approach under which the threshold is higher than the DRG rate by a fixed dollar amount that is the same for every DRG. As a rule of thumb, thresholds tend to be between two and four times as high as the DRG payment. The department calculated the proposed cost outlier thresholds by multiplying the gross DRG by four,

on a DRG-by-DRG basis. Because cost outlier thresholds are set individually for each DRG and depend on the charges for that group, the thresholds for low-volume DRGs (those DRGs with less than five claims) cannot be calculated with confidence. These DRGs have no relative weights and will be paid on a cost-to-charge ratio and therefore, will have no cost outlier thresholds.

The mental health DRGs (DRG 425 through 433) are split by age of the patient (under 18 and 18 or older) when calculating the proposed relative weights and the proposed cost outlier thresholds. The relative weight and the cost outlier threshold for DRG 462 (Rehabilitation) was negotiated with the rehabilitation facilities in 2004 and will not be changed at this time.

ARM 37.86.2912 and 37.86.2914

The department is proposing amendments to update references to Medicare cost reimbursement principles in these rules. Capital-related costs and medical education costs are allowable as provided in federal regulation 42 CFR 412.113. If the references to that regulation were not updated, providers of Medicaid hospital services that also provide Medicare hospital services would be required to use the October 1, 2004 version for Medicaid cost reporting and the October 1, 2005 version for Medicare cost reporting. The department's proposed amendment would conform the Medicaid cost reimbursement principles to those currently used by Medicare and would simplify cost reporting duties for hospitals that provide Medicare and Medicaid services. The department does not intend the proposed amendments to have any effect on rates.

ARM 37.86.2916

The department is taking this opportunity to correct an oversight in this rule. Currently, it provides for the exemption of neonatal DRGs 385 through 389 from the cost outlier payment system. Neonatal DRGs 385 through 389, critical access hospitals and exempt hospitals, are reimbursed actual allowable costs. There is no need for an outlier payment methodology to cover high cost cases requiring those services. If this proposed amendment is not adopted, providers and the public might incorrectly conclude that the neonatal DRGs are the only hospital services exempt from the cost outlier payment methodology. Such a conclusion might lead to unnecessarily increased costs to providers and the department for administrative reviews and hearings necessary to resolve differences in interpretation of the rule. The department does not intend the proposed amendment to have any effect on the current reimbursement rates.

ARM 37.86.2918

The department is taking this opportunity to correct an oversight in this rule providing formulae for calculating reimbursement for inpatient hospital readmissions and transfers. Readmissions and transfer reimbursement rates currently include add-ons for capital expenses, medical education, and disproportionate share hospital

costs in the calculation. Currently, however, the rule does not mention add-ons. If these proposed amendments are not adopted, providers and the public might incorrectly conclude that add-ons are not considered in computing Medicaid reimbursement rates for readmissions and transfers. Such a conclusion might lead to unnecessarily increased costs to providers and the department for administrative reviews and hearings necessary to resolve differences in interpretation of the rule. The department does not intend the proposed amendments to have any effect on the current reimbursement rates.

ARM 37.86.3007

The department has been using the Medicare Clinical Diagnostic Fee Schedule (CLAB) since August 2003 to reimburse Medicaid outpatient hospital clinical diagnostic laboratory services so that Medicaid reimbursement will parallel Medicare. The department is taking this opportunity to propose amendments to conform this rule to current practice. If this proposal was not adopted, hospital laboratories that also provide services to Medicare patients would have to maintain two different coding systems, unnecessarily increasing costs and billing mistakes. Use of the CLAB fee schedule will not have an adverse financial effect on hospitals. The department does not intend the proposed amendments to have any effect on diagnostic laboratory reimbursement rates.

ARM 37.86.3020

The department has used the conversion factor as defined at ARM 37.86.3001 since August 2003 to convert the nationwide Medicare specific relative weight for each APC group into a Medicaid reimbursement rate adjusted for actual Montana costs. The sentence regarding the conversion factor in this rule unnecessarily repeated language from the definition of "conversion factor" in ARM 37.86.3001. This duplication could have resulted in differing interpretations of the rule. The department is proposing an amendment that would delete the duplicated language and would substitute a cross reference to the definition. If the current text was maintained, it might lead to unnecessarily increased costs to providers and the department for administrative reviews and hearings necessary to resolve differences in interpretation of the rule. The department does not intend the proposed amendment to have any effect on the current reimbursement rates.

The department is also proposing an amendment to this rule that would update the current outpatient prospective payment system (OPPS) to incorporate the Medicare Outpatient Prospective Payment System (OPPS) schedules effective January 1, 2006. This proposal would allow the Medicare reimbursement methodology to parallel the Medicare methodology. If Medicaid reimbursement did not parallel Medicare, hospitals would have to maintain different coding systems for Medicare and Medicaid.

ARM 37.86.3105

The department is taking this opportunity to propose an amendment deleting redundant language in this rule requiring a referral to individual case management as a condition precedent to receiving outpatient pulmonary rehabilitation services. If this proposed amendment is not adopted, the unnecessary case management provisions in this rule might result in differing interpretations of the requirements for pulmonary rehabilitation. The current text might lead to unnecessarily increased costs to recipients and the department for duplicate referrals or administrative reviews and hearings necessary to resolve differences in interpretation of the rule. The department does not intend the proposed amendment to have any effect on recipients or hospitals.

Fiscal effects

The department expects the proposed adjustment of relative DRG relative weights and threshold in ARM 37.86.2907 to be budget neutral for State Fiscal Year 2007. Some DRGs will increase and others will decrease, but overall, the proposed amendments will not affect the Medicaid budget. An individual hospital may be affected if it specializes or otherwise provides services in proportions that differ from the average Montana DRG hospital.

None of the other proposed amendments are expected to have a fiscal effect.

Persons and entities affected

In Montana there are 42 critical access hospitals, two exempt hospitals and 24 ambulatory surgical centers eligible to receive Medicaid reimbursement. They would be affected by the proposed reimbursement increases.

Currently, three hospitals meet the standard for Level III neonatal care and provide neonatal services to 71 babies per year. Three hospitals meet the standard for Level II care and provide services to approximately 251 babies per year. All six hospitals would be affected by the proposed amendments to ARM 37.86.2907.

There are 15 DRG hospitals within the state of Montana and 37 DRG hospitals in border states that would be affected by changes in the table of weights and thresholds.

4. The department intends the proposed amendments to be effective October 1, 2006. Although the Medicare OPPS schedules were effective for Medicare purposes January 1, 2006, Montana is proposing to apply them effective October 1, 2006.

5. Interested persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on September 21, 2006. Data, views or arguments may also be submitted by

facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@mt.gov. The department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

6. The Office of Legal affairs, Department of Public Health and Human Services, has been designated to preside over and conduct the hearing.

/s/ John Koch
Rule Reviewer

/s/ Russell Cater for
Director, Public Health and Human Services

Certified to the Secretary of State August 14, 2006.